



Prior Authorization Criteria for Growth Hormone Class

Background

Brand names for growth hormone products (somatropin or somatrem) on the DoD Uniform Formulary include Nutropin, Nutropin AQ, Norditropin, Norditropin Nordiflex, Serostim, Tev-Tropin, and Zorbtive. Genotropin, Humatrope, Omnitrope, and Saizen are non-formulary (Tier 3). All require prior authorization.

The following criteria were established by the DoD Pharmacy & Therapeutics (P&T) Committee for growth hormone products obtained through the TRICARE Mail Order Pharmacy (TMOP) or retail network pharmacies as part of the TRICARE Retail Pharmacy (TRRx) Program. The prior authorization form for growth hormone products is available on the TRICARE Pharmacy Prior Authorization page. This prior authorization is good for a year.

Prior Authorization Criteria for Brand Name (generic name)

All new users of growth hormone products must meet one of the following criteria in order for Prior Authorization to be approved:

Coverage provided for:

- Growth Hormone Deficiency in children and adults as a result of pituitary disease, hypothalamic disease, surgery or radiation therapy
- Chronic renal insufficiency before renal transplantation with associated short stature
- Other known renal indications: autorecessive polycystic kidney disease, cystinosis and hypophosphatemic rickets in the pediatric population
- Short stature in patients with Turner Syndrome or Prader-Willi syndrome
- Infants born small for gestational age that have not reached age appropriate height by 24 months of age
- Human immunodeficiency virus-associated wasting in adults
- Noonan Syndrome
- Short stature homeobox gene (SHOX) deficiency

Coverage NOT provided for:

- Idiopathic Short Stature
- Depression, Aging or Obesity

Criteria approved through the DOD P&T Committee process Meeting Month, Meeting Year

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TRICARE Management Activity,
a component of the [Military Health System](#)
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Growth Hormone Prior Authorization Request Form



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To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) TRICARE pharmacy program (TPHARM). Express Scripts is the TPHARM contractor for DoD

MAIL ORDER
and
RETAIL

- The provider may call: **1-866-684-4488**
or the completed form may be faxed to:
1-866-684-4477

- The patient may attach the completed form
to the prescription and mail it to: **Express Scripts, P.O. Box 52150, Phoenix, AZ 85072-9954**
or email the form only to:
TpharmPA@express-scripts.com

Prior authorization criteria and a copy of this form are available at: http://pec.ha.osd.mil/forms_criteria.php. Approval is good for one year.

Step 1 Please complete patient and physician information (Please Print)

Patient Name: _____ Physician Name: _____
Address: _____ Address: _____
Sponsor ID# _____ Phone #: _____
Date of Birth: _____ Secure Fax #: _____

Step 2 Please indicate the specific product for which prior authorization is requested: _____

DoD preferred (formulary) growth hormone products include: Norditropin, Norditropin Nordiflex; Nutropin, Nutropin AQ; Serostim, Tev-Tropin; and Zorbtive.

Non-formulary growth hormone products: Genotropin, Humatrope, Omnitrope, and Saizen

Step 3 Please complete the clinical assessment

1. Is the patient a child (<18 years old)?	<input type="checkbox"/> Yes Please proceed to question 5	<input type="checkbox"/> No Please proceed to question 2
2. Is the patient an adult with lowered growth hormone levels secondary to the normal ageing process, obesity or depression?	<input type="checkbox"/> Yes Coverage not approved	<input type="checkbox"/> No Please proceed to question 3
3. Is the patient an adult with growth hormone deficiency as a result of pituitary disease, hypothalamic disease, trauma, surgery, or radiation therapy, acquired as an adult or diagnosed during childhood?	<input type="checkbox"/> Yes Please sign and date below	<input type="checkbox"/> No Please proceed to question 4
4. Does the patient have Short Bowel Syndrome or Acquired Immunodeficiency Syndrome (AIDS) wasting or cachexia?	<input type="checkbox"/> Yes Please sign and date below	<input type="checkbox"/> No Coverage not approved
5. Is the patient a child with non-growth hormone deficient short stature (Idiopathic Short Stature)?	<input type="checkbox"/> Yes Coverage not approved	<input type="checkbox"/> No Please proceed to question 6
6. Is the patient a child with one of the following conditions? <input type="checkbox"/> Growth Hormone Deficiency <input type="checkbox"/> Prader-Willi Syndrome <input type="checkbox"/> Turner's Syndrome <input type="checkbox"/> Short stature homeobox gene (SHOX) deficiency <input type="checkbox"/> Noonan Syndrome <input type="checkbox"/> Small for gestational age (or other known renal indications)	<input type="checkbox"/> Yes Please proceed to question 7	<input type="checkbox"/> No Coverage not approved
7. Has the patient been evaluated by a pediatric endocrinologist or nephrologist who recommends therapeutic intervention and will manage treatment?	<input type="checkbox"/> Yes Please sign and date below	<input type="checkbox"/> No Coverage not approved

Step 4 I certify that the above is correct to the best of my knowledge (Please sign and date):

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Prescriber Signature

Date